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The Art of Psychotherapy

Selecting Patients for Psychodynamic Psychotherapy

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EDITOR'S NOTE: All cases presented in the series "Psychotherapy Rounds" are composites constructed to illustrate teaching and learning points, and are not meant to represent actual persons in treatment.

A preliminary challenge in learning the art of psychotherapy is mastering how to choose appropriate patients. This skill goes far beyond performing a symptom inventory and matching up those results to a diagnosis. A psychodynamic evaluation explores various innate characteristics that predict a patient's ability to participate fully in and benefit greatly from this mode of therapy. Ignoring this critical first step in the process may create unnecessary stumbling blocks in the road of treatment. In this article, we will use a case example to illustrate some of the consequences a poor fit bears for both the patient and the therapist; in addition, we will review the desired traits that support a patient's suitability for psychodynamic psychotherapy.

INTRODUCTION

The art of psychotherapy can unfortunately get lost in today's busy psychiatric residencies, amidst all of the genetic, biologic, psychotherapeutic, psychosocial, and educational topics necessary to impress upon trainees prior to graduation. Even among programs that emphasize psychotherapy as a valued skill, the essential task of how to select patients appropriately for various types of psychotherapy can be overlooked. Skipping the vital topic of assessing a patient's suitability for a particular type of psychotherapy does service to no one. Competent evaluation of the patient in this regard is not an easy skill to master or to impart to others. As Malan eloquently stated, accurate patient selection is "probably the most complex, subtle, and highly skilled procedure in the whole field."[1] Choosing patients that are appropriate for psychotherapy is particularly crucial in the setting of a residency clinic, where new clinicians receive their first impressions of the effectiveness of psychotherapy. The consequences of a poor fit for therapy can be disastrous; the patient, the resident or trainee, and the supervisor suffer hardship, and the confidence that each has in the overall effectiveness of therapy as a helpful treatment can be shaken.

OUR RESIDENCY PROGRAM

In our psychiatric training program at the Boonshoft School of Medicine, Wright State University, the residents conduct a

psychotherapy clinic, focusing on long-term psychodynamic therapy as the main treatment modality, along with competencies in cognitive, behavioral, brief, marital, and family therapies. The residents' time in the clinic is assigned and protected, and weekly individual supervisory sessions with designated faculty members are required. Provisions are also made for onsite emergency supervision. Psychotherapy case conferences, in which the residents formulate and present their cases to their peers and faculty for discussion, are a weekly component of the didactic curriculum throughout the four-year program. Each therapy office in the clinic is equipped with a wall-mounted video camera to record sessions. With the patients' explicit consent, these videos can be used in supervision and case conferences.

Lack of attention to the critical skill of selecting patients who will most likely benefit from psychotherapy might quickly undo even these concentrated efforts to teach the art and science of psychotherapy to residents. In Wright State's case, referrals to the clinic come from all over the city and are sorted by the clinical chief resident who contacts prospective patients by phone. These preliminary conversations serve to divert more unstable patients toward treatment venues outside of the psychotherapy clinic. Patients who pass this cursory examination are scheduled with a resident for initial consultation sessions.

At this point, it is understood that the patient and the resident have committed only to diagnostic sessions, the goal of which would be to uncover the patient's history, life circumstances, and enduring traits that speak to their suitability for dynamic psychotherapy. This demands interviewing and formulation skills of the resident that are immensely different from the daily admitting histories obtained on the inpatient wards. Far from symptom checklists and rote diagnoses, the resident must be taught to discern qualities in the patient that will demonstrate the patient's ability to use psychotherapy effectively, to embark on a collaborative journey of self-discovery that is not always easy or comfortable, and to stay the course through adversity to the goal of growth and new insight. Ignoring this critical first step in psychotherapy can be problematic and lead to a lackluster experience for the patient and the resident physician, in what is perhaps his or her first exposure to the power of psychotherapy to heal.

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A CASE STUDY

Upon referral from her family physician, Ms. M (composite case, not an actual person in treatment) presented requesting psychotherapy. Her initial complaint was phrased as "depression, I guess." She was a 30-year-old woman who had been receiving escitalopram, bupropion, and valproate for the last year for a diagnosis of bipolar disorder, with minimal relief. She reported symptoms of a variable sleep cycle, feelings of hopelessness, and difficulty sustaining concentration. She felt alienated, misunderstood, and alone most days. During the preceding two years, she had become increasingly frustrated even with her previously enjoyed hobbies, such as singing and line dancing. She was quickly irritable with others, particularly her parents, and had harbored chronic thoughts of death and suicide since childhood.

She arrived on time at the clinic for sessions but with marginal grooming. She exhibited psychomotor agitation, fidgeting in her seat and with her clothes, and she had marked difficulty in maintaining eye contact with the resident psychiatrist. She was obviously anxious and uncomfortable and developed only a strained rapport. Her thoughts were largely organized and she demonstrated some capacity to think abstractly.

Her previous diagnosis of bipolar disorder rested on symptoms of "violent mood swings" and "racing thoughts." She also reported that she had heavily used alcohol, marijuana, and prescription opiates and benzodiazepines as a teenager, quitting on her own two years prior to presentation. In early sessions,

Ms. M denied substance use; she later acknowledged that she remained a frequent user of alcohol and marijuana.

Weekly psychotherapy sessions were started. The therapist soon was surprised to uncover more complex details of the patient's upbringing and social circumstances that had not been elicited before beginning treatment—details that would have an impact on diagnoses and the outcome of the therapy.

DEFINITIONS OF PSYCHODYNAMIC PSYCHOTHERAPY

To appropriately select patients for psychodynamic psychotherapy, a basic understanding of its tenets provide necessary context. Referred to by various terms, including *psychodynamic, dynamic, psychoanalytic*, and *expressive* psychotherapy, among others, this treatment is descended from psychoanalysis and retains focus on the emotional intimacy of the therapeutic relationship, both in reality and in transference. This partnership serves as a haven for the exploration of the patient's difficulties in past and current relationships, as they are discussed and re-experienced with the therapist.[2] By emphasizing emotional variations and insights, these emerging patterns are confronted together and investigated, to bring into the consciousness what was once buried. The principal technique is interpretation, in which the therapist puts forth a hypothesis to explain the unconscious significance and origin of behaviors. Interpretations are designed to bring into awareness the use of primitive and maladaptive defenses and to explore the meaning of transference phenomena as it happens in the session.[2]

As opposed to more formal psychoanalysis, dynamic psychotherapy recognizes the important role of mutual engagement between the patient and the therapist as a curative element. This form of therapy addresses psychological problems from the perspectives of early intrapsychic conflicts and developmental failures. As intrapsychic conflicts are resolved, the patient is able to experience the therapist with fewer distortions from childhood. These new insights empower the patient to break self-defeating patterns of behavior, thereby making better decisions and mastering a sense of autonomy in life.[3] Psychodynamic psychotherapy encompasses a continuum of techniques, ranging from expressive to supportive, and a skilled therapist will strike a balance between these poles for the benefit of the patient's exploration, depending on the material presented at the time.

ANALYZABILITY

The historical origins of psychoanalysis in the work of Freud reflect a notion of selecting patients for this form of treatment. These requirements were based on the recognition of the arduous demands that analysis places on the patient. In those early times, the classic medical model of uncovering diagnostic "indications" for treatments predominated, but desirable traits in the constitutions of analysands were noted.[4]

Modern concepts of analyzability have evolved from these roots into a constellation of capacities necessary in a patient to benefit from treatment in analysis. Criteria for analyzability transcend strict lists of amenable diagnoses to include ideal traits in a patient. These are intended to designate which patients will be able to tolerate the deep exploration, to forge a therapeutic alliance, and ultimately to work in the transference. See Table 1 for a list of traits.[6]

Analysts, and later dynamic therapists, seek out in their patients an internal sense of responsibility for their lives with some ability to control their circumstances.[5] They look for sufficient suffering in the patient to motivate him or her for treatment, for a genuine wish for examination and self-understanding, and for strength to withstand the anxiety, disturbances, and intense effects that accompany psychoanalytic treatment.[6]

TABLE 1. Selection criteria for dynamic psychotherapy

- Ample ego and superego development
- History of successful attachment
- Motivation and will to improve
- Capacity for introspection
- Psychological mindedness
- Autoplastic defenses
- Tolerance of strong affects
- Demonstration of social and vocational effort
- Ability to trust
- Capacity for empathy
- Sufficient intelligence and verbal ability
- Ability to use analogy and metaphor
- Evidence of self control

CASE STUDY CONTINUED

The initial goal of therapy with Ms. M was to create a safe environment for exploration and to build a sound therapeutic rapport. The therapist eventually settled on diagnoses of dysthymic disorder, cannabis dependence, alcohol dependence, nicotine dependence, and social phobia, along with dependent and borderline personality traits. It was thought that Ms. M's diagnoses were adequate indications for dynamic psychotherapy; however, the patient was described as needing "extensive socialization into therapy." Ms. M primarily employed primitive defenses, including projection, withdrawal, turning against the self, and acting out. Within the initial formulation, the therapist noted various insights into the patient's character and development, which seemed to argue against dynamic therapy as an appropriate modality. These comments included, "lacking in

psychological mindedness," "difficult flow of thought and content," and "very limited ability to access emotions." These concerning observations, however, unfortunately were not explored further, and expressive therapy was pursued with little success. Unable to see past her intense pain and distress, Ms. M became impatient with attempts to promote greater understanding of herself. She rebuked the idea of increased autonomy, preferring instead the small comforts derived from her disabled role within her family.

As the tedious sessions progressed, the therapist became increasingly uncomfortable with material that was emerging; she worried about the patient's stability and basic safety in the community. Dynamic processes and interventions seemed to increase the patient's agitation, and she did not improve. Ultimately, Ms. M was hospitalized during the sixth month of treatment after a serious suicide attempt.

SUITABILITY FOR DYNAMIC THERAPY

As opposed to historical times in analysis, more therapists now consider characterological qualities within the patient more than diagnoses when assessing suitability for dynamic treatment.[7] The distinguishing attributes of patients who can use and benefit from expressive therapy have less to do with specific diagnoses than with constructs that suggest ego strength, cohesive identity, and self control.[8] The assessment for dynamic therapy depends more on the discernment of suitable traits than on the report of symptoms. Diagnoses themselves are considered less reliable in the prediction of successful treatment; they are taking second place to elucidating the presence of an ego healthy enough to endure psychoanalytic psychotherapy. For example, it seems not to be a question of whether dynamic therapy is appropriate for treating depression, but instead whether a depressed individual possesses the internal qualities necessary for dynamic therapy to be of help.[4]

Analyzable patients have introspective minds and autoplastic defenses that look inward for the source of their behavior patterns, rather than being externally focused on others as the sole causes for their suffering.

In fact, many patients who do not fit any specific diagnosis outlined in DSM-IV-TR nonetheless experience significant distress and impairment in life and seek treatment for problems with intimacy, assertiveness, avoidance, self-defeating behaviors, shyness, loss, or unresolved grief, to name a few. Such patients may derive great benefit from dynamic psychotherapy as the primary modality for these troubles, based on their suitable personality traits and characterological structure rather than on their diagnoses.[6] These characteristics reveal underlying structures in the patient's psyche—upon which the ability to associate freely depends—and from which transference can emerge.[9]

SELECTION CRITERIA

Various authors have suggested innate characteristics in candidates related to their suitability for dynamic psychotherapy. Stone discusses concepts such as "likeableness," which describes the patient's will to get better, as well as his or her capacity to connect and cooperate within the therapeutic encounter. Analyzable patients have an introspective mind and autoplastic defenses that look inward for the source of their behavior patterns, rather than being externally focused on others as the sole causes for their suffering. Stone favors patients who display courage and tolerance in the face of their emotional problems; in addition, patients who have demonstrated effort in their lives, socially or vocationally, imply that they possess autonomy and a will to persevere and make life better for themselves.[7]

Silver points out that a history of prior interpersonal relationships is a necessary capacity for prospective patients, as it indicates an aptitude to develop a therapeutic alliance.[10] Any difficulties experienced within these past relationships will likely resurface within the therapeutic process in the room. On the other hand, the way the patient relates to the therapist during the assessment phase may be more reliable, in fact, than any historical data that is provided. Other important capacities include the ability to psychologically self-soothe, to trust, to experience pleasure and creativity, to tolerate delay or frustration, and to empathize with others. A well-timed exchange of humor during initial sessions can serve as a measure of empathic abilities.[10]

Many authors, hearkening back to Freud himself, describe the patient's degree and acuity of pain as vital to provide the internal motivation to endure the sometimes difficult process of dynamic

psychotherapy. The pain that the patient carries is the very thing that energizes him or her to sacrifice time, finances, and effort to get better.[6] If too little pain is present in patients, they may not see the exertion of therapy as a necessary undertaking; pain that is too severe will diminish their ability to focus on anything else.

Intelligence is crucial to developing a sufficient degree of insight, a primary goal of analytic psychotherapy. This can be demonstrated in the patient's capacity to verbalize thoughts and emotions and to think in analogy and metaphor, all critical to working in the transference.[3] The patient's response to trial interpretations delivered during the initial consultation sessions can also predict to some extent the suitability of the patient to work in therapy.[11]

Patients who exhibit more self control in their histories tend to be more suitable for the stresses inherent in expressive therapy. A history free of repetitive chaos indicates that the patient will likely be able to adhere to the therapeutic frame and will be reliable in attending appointments and fulfilling financial responsibilities.[11]

PSYCHOLOGICAL MINDEDNESS

The term *psychological mindedness* is frequently used in therapy circles, including residency training programs, but it is seldom defined. A prospective patient's degree of psychological mindedness can be assessed according to his or her interest in discovering the nature of his or her problems, rather than in passively receiving relief from the clinician. It speaks to the patient's capacity for objectivity, for reflecting on his or her own emotions and related behaviors, and for handling new awareness of his or her faults. Psychological mindedness also entails the strength of the patient's aims and values, as well as his or her willingness to consider and implement alternative strategies that come to light in sessions.[7]

A measure of this desire to understand the meaning of internal experiences can be drawn from impressions of the patient formed throughout initial therapy sessions, based on both the history given and the manner in which it is communicated. Psychological mindedness could be more directly tested during consultation by the use of trial interpretations. Another method to accomplish this would involve opening the second consultation session by asking the patient if he or she had any thoughts he or she would like to discuss that had come up since the first session. If the patient indicates that he or she has not really thought about anything since the initial meeting, he or she may have little capacity for psychological mindedness. If, however, the patient responds to this question more enthusiastically, offering comments on emotions or other memories that have emerged since the first session, he or she may have more promise regarding this characteristic.[10]

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CASE STUDY CONCLUDED

After numerous sessions with a dynamic focus, it became clear that psychotherapy was leaving the patient more symptomatic and agitated and the therapist frustrated and doubtful of her abilities. A switch in technique to supportive psychotherapy was employed for the remainder of the treatment. This retained the psychodynamic understanding of Ms. M that had been constructed thus far, but allowed the patient a more safe and manageable session each week. In this way, Ms. M could more easily tolerate the anxiety that arose from becoming aware of her emotions and participating in a healthy therapeutic relationship. More concrete goals were established in a collaborative fashion, including taking a class at the community college and establishing beneficial friendships in her life.

A marked decrease in suicidality, self-mutilation, violent fantasies, and preoccupation with death was observed with these changes. Much of the time in session was now focused on reinforcing this tangible improvement in Ms M. The therapist encouraged her to take these small steps away from the comfort of her sick role and toward some measure of autonomy in the future.

Ms. M and the therapist discussed events in the patient's life

with a problem-solving focus. They brainstormed solutions and ways to implement them. At subsequent sessions, they reviewed the progress and made alterations to Ms. M's plans, with advice from the therapist where helpful. Planning for termination of therapy and referral back to the family physician

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involved patient input and supported autonomy while paying due attention to providing sufficient follow-up care. Throughout this phase, Ms. M was able to more confidently assert the emotions she was having about therapy ending and about how important this relationship was in her life, without reverting to previous destructive ways of allaying stress.

LEARNING POINTS AND CONCLUSIONS

A residency program that endeavors to comprehensively train psychiatrists must not lose sight of the unique, artful skill of psychodynamically understanding patients. Psychiatrists who are first psychotherapists will have a broader arsenal with which to help the mentally ill as well as the emotionally distressed individuals. This can increase satisfaction both in patients and in therapists. In turn, a key to successful psychodynamic psychotherapy is selecting appropriate patients at the outset, those who possess the intrinsic characteristics needed to make full use of the treatment. Without vigilant attention to this first stage, both the patient and the therapist may suffer unnecessary tension, anxiety, and potential disillusionment. Attempting to train residents as therapists without thought to the skills and tasks implicit in the psychodynamic evaluation of prospective patients will very likely yield negative learning experiences, which may not be as beneficial to the patient and may permanently color the resident's attitude about his or her own capabilities and the healing promise of psychotherapy.

In this regard, diagnoses offer less information and predictive power than do explorations of a patient's inner characteristics. Innate capacities for trust, expression, tolerance, diligence, insight, observation, and self control better describe a suitable candidate for psychodynamic psychotherapy than diagnostic labels of depression or anxiety by themselves. A patient's ability to look inward for meanings of behaviors and patterns and his or her desire to learn about these internal factors, termed *psychological mindedness*, is the key to benefiting from dynamic psychotherapy. The rewards for suitable patients, however, outweigh many times over the effort involved; they are paid out in new, autonomous abilities within patients to lead their own lives.

REFERENCES

1. Ogrodniczuk JS, Joyce AS, Piper WE. Strategies for reducing patient-initiated premature termination of psychotherapy. *Harv Rev Psychiatry* 2005;13(2):57–70.
2. Gomez JR. Psychoanalytic psychotherapy and its indications. *J Med Assoc Ga* 1986;75(10):623–5.
3. Kay J, Kay RL. Individual psychoanalytic psychotherapy. In: Tasman A, Kay J, Leiberman JA (eds). *Psychiatry, Second Edition.* Hoboken, NJ: Wiley Publishers, 2003:1705–9.
4. Tyson RL, Sandler J. Problems in the selection of patients for psychoanalysis: comments on the application of the concepts of 'indications,' 'suitability,' and 'analysability.' *Br J Med Psychol* 1971;44(3):211–28.
5. Crown, S. Contraindications and dangers in psychotherapy. *Br J Psychiatry* 1983;143:436–41.
6. Psychotherapies. In: Kaplan HI, Sadock BJ, Sadock VA (eds). *Comprehensive Textbook of Psychiatry, Eighth Edition.* Philadelphia, PA: Lippincott Williams & Wilkins, 2004.
7. Stone, MH. Analytically oriented psychotherapy in schizotypal and borderline patients: At the border of treatability. *Yale J Biol Med* 1985;58:275–88.
8. Bjorklund P. Assessing ego strength: Spinning straw into gold. *Perspect Psychiatr Care* 2000;36(1):14–23.
9. Bachrach HM, McNutt ER. Psychoanalysis and psychoanalytic psychotherapy: Similarities and differences, indications, contraindications, and initiation. Scientific proceedings. New York, NY: American Psychoanalytic Association Annual Meeting, December 16, 1986.
10. Silver D. Psychotherapy with the characterologically difficult patient. *Can J Psychiatry* 1983;28:513–21.
11. Blenkiron P. Who is suitable for cognitive behavioral therapy? *J Royal Soc Med* 1999;92:222–9.